

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 May 2003

In the Matter of

MR. RAY BOLLING
Claimant

Case No.: 2002 BLA 201

v.

BETTY B. COAL CO., INC.,
Employer

and

LIBERTY MUTUAL INSURANCE
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances:

Mr. Joseph E. Wolfe, Attorney
For the Claimant

Mr. H. Ashby Dickerson, Attorney
For the Employer

Before:

Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER -
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. Ray Bolling for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Pursuant to a Notice of Hearing, dated March 26, 2002 (ALJ I),¹ I conducted a hearing on June 26, 2002 in Abingdon, Virginia with Mr. Bolling, Mr. Wolfe, and Mr. Dickerson. My decision in this case is based on all documents admitted into evidence: DX 1 to DX 39² and EX 1 to EX 11.³

Procedural Background

First Claim

On September 27, 1982, Mr. Bolling filed his first claim for black lung disability benefits under the Act (DX 35-1). After a pulmonary examination had been completed, the District Director denied Mr. Bolling's claim on May 20, 1983 for failure to prove pneumoconiosis or total respiratory disability (DX 35-17). On July 19, 1983, Mr. Bolling objected to the denial and requested a hearing with the Office of Administrative Law Judges ("OALJ") (DX 35-18). A formal hearing was held on January 6, 1988 in Kingsport, Tennessee. By Decision and Order, dated February 24, 1988, Administrative Law Judge John J. Forbes, Jr. denied Mr. Bolling's first claim because he failed to prove the presence of pneumoconiosis and a total disability (DX 35-32). On May 1, 1990, the Benefits Review Board affirmed Judge Forbes' denial of benefits (DX 35-37).

Second Claim

On December 7, 1994, Mr. Bolling filed his second claim for benefits (DX 36-1). Following a pulmonary examination, Dr. Forehand concluded Mr. Bolling's obstructive pulmonary defect was related to his coal mine employment, especially the earlier portion of that employment prior to dust controls. At the same time, due to a repeat function study dated May 18, 1995, Dr. Forehand reasoned that Mr. Bolling had the residual ventilatory capacity to return to his last coal mining job as a belt watcher (DX 36-17). As a result, on May 31, 1995, the District Director denied Mr. Bolling's second application for benefits for failure to establish total disability (DX 36-19).

Third Claim

Mr. Bolling filed his third claim on March 4, 1997 (DX 37-1). Since the pulmonary examination demonstrated no evidence of pneumoconiosis (DX 37-7), the District Director issued a Show Cause Order on March 19, 1997 indicating to Mr. Bolling that his claim would be denied due to abandonment absent additional evidence or a request for a hearing on his claim (DX 37-12). No new evidence was submitted to process the claim. Consequently, the District Director denied Mr.

¹The following notations appear in this decision to identify specific evidence and other documents: DX - Director exhibit; EX - Employer exhibit; ALJ - Administrative Law Judge exhibit; and, TR - Transcript of hearing.

²Subsequent to the hearing, on August 12, 2002, Employer's counsel withdrew his objection to a chest x-ray interpretation in DX 35. I now admit that portion of DX 35 into the record.

³Mr. Bolling elected not to testify (TR, page 21).

Bolling's third application for benefits on July 11, 1997 (DX 37-13).⁴

Fourth Claim

Mr. Bolling filed his fourth claim on March 23, 2000 (DX 1). On June 23, 2000, the District Director issued a Show Cause Order indicating to Mr. Bolling that his claim would be denied due to abandonment absent a reasonable explanation for his failure to respond to the request for a medical examination (DX 6). After a rescheduled a pulmonary examination by Dr. Rasmussen, the District Director rendered a preliminary decision on May 9, 2001 finding Mr. Bolling eligible for benefits (DX 19). The employer contested the entitlement and requested an extension to develop its case (DX 20). After a pulmonary examination by Dr. Dahhan (DX 22), the District Director again granted benefits (DX 25). By letter dated September 26, 2001, the employer requested a formal hearing before the OALJ (DX 32). Thereafter, the District Director initiated interim benefits to Mr. Bolling and forwarded the case to OALJ on December 31, 2001 (DX 38). I eventually conducted the hearing on June 26, 2002.

Miner's Background

Born on January 27, 1918, Mr. Bolling married the late Mrs. Mary Alice Bolling on November 11, 1939 (DX 35-4). According to Department of Labor claim forms completed in February 2001, Mr. Bolling periodically worked in the coal mine industry between 1932 and 1982. During that time, Mr. Bolling drilled and shot coal. He also worked as a cutting machine operator, hand loader and loading machine operator (DX 12). That work ended in 1978 or 1979 due to a lay-off (DX 1). Mr. Bolling was a lifelong non-smoker (DX 12).

ISSUES

1. Whether Mr. Bolling, in filing a duplicate claim on March 23, 2000, has established a material change in condition since the denial of his most recent prior claim in July 1997.
2. If Mr. Bolling establishes a material change in conditions, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

⁴According to 20 C.F.R. § 725.409 (c), for the purposes of evaluating a subsequent duplicate claim, a denial by reason of abandonment is deemed a finding that the claimant did not "establish any applicable condition of entitlement."

Stipulations of Fact

At the hearing, the parties stipulated Mr. Bolling has at least 11 years of post 1969 coal mine employment and Betty B. Coal Company is the responsible operator (TR, pages 10 and 11).

Issue #1 - Material Change in Condition

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; *see* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. § 725.309⁵ as interpreted by the Benefits Review Board and federal Courts of Appeals. Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994):

[T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Fourth Circuit, which has jurisdiction over this claim, has followed the *Sharondale* approach. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd* 86 F.3d 1358 (4th Cir. 1996) (*en banc*). I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In determining whether there has been a material change in condition, I will focus on the four

⁵Although the new revision of the regulations included changes to 20 C.F.R. § 725.309 (2000) relating to material change in conditions, the former version of 20 C.F.R. § 725.309, with the corresponding court interpretations, still applies to Mr. Bolling's claim.

basic elements a claimant must prove by preponderance of the evidence. First, the miner must establish the presence of pneumoconiosis. Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.⁶ Third, the miner has to demonstrate he is totally disabled.⁷ And fourth, the miner must prove the total disability is due to pneumoconiosis.⁸

Based on the above regulatory provisions and case law, the first step in the material change adjudication requires the identification of the elements a claimant failed to prove in the prior claim. Usually, the only elements of entitlement that are capable of changing are whether a miner has pneumoconiosis or whether he has become totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

Based on Mr. Bolling's abandonment of his 1997 claim, the District Director's denial at that time represents a failure by the claimant to prove any element of entitlement. At the same time, I note that in the second claim, he was able to establish the presence of pneumoconiosis through the uncontradicted medical opinion of Dr. Forehand. Consequently, for purposes of the material change determination, I will evaluate the evidence developed since July 1997 to determine whether Mr. Bolling is able to prove the presence of a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. The U.S. Court of Appeal for the Third Circuit has held that, in order to establish total disability due to

⁶20 C.F.R. § 718.203 (a).

⁷20 C.F.R. § 718.204 (b).

⁸20 C.F.R. § 718.204 (a).

pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.⁹

Mr. Bolling has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains insufficient evidence of complicated pneumoconiosis. As a result, Mr. Bolling must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	Date/ Doctor	Age/ height	FEV ₁ pre ¹⁰ post ¹¹	FVC pre post	MVV pre post	%FEV ₁ / FVC pre post	Qualified ¹ pre post	Comments
DX 10	Feb. 7, 2001 Dr. Rasmussen	83 67"	1.15 1.31	2.72 3.44	47 56	42% 38%	Yes ¹³ Yes	Severe, partially reversible obstructive ventilatory defect
DX 10	(same) Dr. Michos	--- ---	--- ---	--- ---	--- ---	--- ---	--- ---	Vents acceptable with suboptimal MVV performance
DX 23-2	June 8, 2001 Dr. Dahhan	83 67"	0.95 0.54	1.77 1.07	15 9	54% 50%	Yes Yes	Claimant unable to take in good deep breath and hold for 10 seconds
DX 23-1	(same) Dr. Michos	--- ---	--- ---	--- ---	--- ---	-- --	-- --	Vents not acceptable; less than optimal effort

Under the provisions of 20 C.F.R. §718.204 (c) (1), if the preponderance of the pulmonary

⁹See *Beatty v. Danri Corp. & Triangle Enterprises and Dir.*, OWCP, 49 F.3d 993 (3d Cir. 1995).

¹⁰Test result before administration of a bronchodilator.

¹¹Test result following administration of a bronchodilator.

¹²Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV₁ must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. §718, **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV₁/FVC has to be equal or less than 55%.

¹³The qualifying FEV₁ number is 1.63 for age >71 and 67"; the corresponding qualifying FVC and MVV values are 2.12 and 65.

function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary test evidence shall establish a miner's total disability. Adjudication under this regulatory section requires a five step process.

First, an administrative law judge must determine whether the tests conform to the pulmonary function test procedural requirements in 20 C.F.R. §718.103. Second, the results are compared to the qualifying values for the various tests listed in Appendix B to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these guidelines in mind, I first observe that both tests appear to conform to procedural requirements and additionally produced sufficient values to qualify under the regulations to establish total respiratory disability. However, issues concerning the validity of both test have been raised. In regards to the June 28, 2001 study, most physicians concluded the test was invalid. So do I.

Concerning the validity of the February 7, 2001 test, Dr. Rasmussen, Dr. Michos, and Dr. Castle found the study sufficiently valid, despite some problem with the MVV portion. Dr. Dahhan and Dr. Fino disagreed, concluding the study was not valid due lack of optimum effort. Since three of the five physicians found the test valid, I conclude the test is valid. Additionally, as the only conforming valid pulmonary function study conducted since 1997, the test demonstrates that Mr. Bolling is totally disabled under the regulations.

Turning to the last consideration in this process, as to be discussed later in more detail, Dr. Dahhan and Dr. Fino presented evidence contrary to a finding of total disability based on this pulmonary function test. Both physicians found insufficient objective medical evidence to conclude Mr. Bolling had a totally disabling respiratory impairment. They also noted the normal arterial blood gas studies. In contrast, Dr. Rasmussen and Dr. Castle were equally convinced that Mr. Bolling did have a totally disabling respiratory impairment. Additionally, the presence of normal arterial blood gas studies does not necessarily preclude establishing a pulmonary disability through pulmonary function studies. Thus, this even split in the medical opinion represents an evidentiary draw that is insufficient to be considered contrary evidence.¹⁴ Absent sufficient contrary evidence, I find the February 7, 2001 pulmonary function study establishes that Mr. Bolling is indeed totally disabled in terms of pulmonary capacity.

¹⁴Although on other subsequent issues I found that some of the medical opinions had diminished relative probative weight, concerning the validity of the pulmonary function tests, each physician rendered an equally probative opinion.

Since the pulmonary function study evidence developed since the denial of Mr. Bolling's prior claim establishes that he is now totally disabled, Mr. Bolling has established a material change in conditions. As a consequence, under the provisions of 20 C.F.R. §725.309, I must now review the entire record in this case to determine whether he is entitled to benefits under the Act.

Issue #2 - Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Bolling must prove that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment. The regulatory definitions include both clinical pneumoconiosis, the diseases recognized by the medical community as pneumoconiosis and legal pneumoconiosis, any chronic lung disease arising out of coal mine employment. 20 C.F.R. § 725.201 (a) (1) and (2).¹⁵ The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 725.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),¹⁶ and physician medical opinion (§ 718.202 (a)(4)).

Because Mr. Bolling has not presented evidence of complicated pneumoconiosis and he filed his duplicate claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, the official record obviously does not contain an autopsy report, and Mr. Bolling has not submitted a biopsy report. As a result, Mr. Bolling will have to rely on chest x-ray evidence or medical opinion to establish the presence of pneumoconiosis. In addition, under the

¹⁵Since Mr. Bolling filed his claim in March 2000, the U.S. Department of Labor ("DOL") has published new regulations concerning black lung disability benefits. Most of the provisions in Part 718 of those new regulations are applicable to his case.

¹⁶If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

guidance of *Compton*,¹⁷ I must consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Bolling can establish pneumoconiosis.

Chest X-Rays

Date of X-Ray	Exhibit	Physician	Interpretation
February 1, 1980	DX 35	Dr. Morgan	Negative for pneumoconiosis
(same)	DX 35	Dr. Wheeler, BCR, B ¹⁸	Negative for pneumoconiosis
(same)	DX 35	Dr. Pendegrass, BCR, B	Negative for pneumoconiosis
November 3, 1982	DX 35	Dr. Morgan	Negative for pneumoconiosis
(same)	DX 35	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Pendegrass, BCR, B	Negative for pneumoconiosis
February 16, 1983	DX 35	Dr. Gaziano, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Gale	Negative for pneumoconiosis, profusion 0/1, ¹⁹ type q/p opacities ²⁰

¹⁷See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

¹⁸B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

¹⁹The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

²⁰There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5
(continued...)

May 23, 1984	DX 35	Dr. Stinett	Some interstitial changes, left base
(same)	DX 35	Dr. Wiot, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Spitz, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Scott, BCR, B	Negative for pneumoconiosis
September 5, 1986	DX 35	Dr. Shah	Negative for pneumoconiosis
April 16, 1987	DX 35	Dr. Shah	Negative for pneumoconiosis
April 28, 1987	DX 35	Dr. Wiot, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Stewart, BCR, B	Negative for pneumoconiosis, infiltrate left base
(same)	DX 35	Dr. Castle, BCR, B	Negative for pneumoconiosis, acute pneumonia
(same)	DX 35	Dr. Hippensteel, BCR, B	Negative for pneumoconiosis, infiltrate left base
(same)	DX 35	Dr. Byers, A	Negative for pneumoconiosis, profusion 0/0
September 4, 1987	DX 35	Dr. Modi	Positive for pneumoconiosis, profusion 2/2, type q/t opacities
September 21, 1987	DX 35	Dr. Haines	Some scarring in right lower lobe
(same)	DX 35	Dr. Wiot, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Stewart, BCR, B	Negative for pneumoconiosis, infiltrate left base
(same)	DX 35	Dr. Castle, BCR, B	Negative for pneumoconiosis
(same)	DX 35	Dr. Hippensteel, BCR, B	Negative for pneumoconiosis
January 10, 1995	DX 36	Dr. Gaziano, B	Negative for pneumoconiosis
(same)	DX 36	Dr. Shanhan, BCR	Negative for pneumoconiosis, bilateral basilar atelectasis
March 3, 1997	EX 1	Dr. Spitz, BCR B	Negative for pneumoconiosis
(same)	EX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis

²⁰(...continued)

millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

April 22, 1997	DX 37	Dr. Wicker, B	Negative for pneumoconiosis, no acute pulmonary disease
(same)	DX 37	Dr. Sargent, BCR, B	Negative for pneumoconiosis
July 12, 1999	EX 8	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	EX 9	Dr. Scott, BCR, B	Negative for pneumoconiosis
August 24, 2000	DX 33	Dr. Dahhan, BCR, B	Negative for pneumoconiosis
(same)	EX 3	Dr. Spitz, BCR, B	Negative for pneumoconiosis
(same)	EX 4	Dr. Wiot, BCR, B	Negative for pneumoconiosis
February 7, 2001	DX 13 DX 14	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion 1/0, type p/s opacities, mild chronic obstructive pulmonary disease (“COPD”)
(same)	DX 18	Dr. Rasmussen	Negative for pneumoconiosis
(same)	DX 15	Dr. Barrett, BCR, B	Negative for pneumoconiosis
(same)	DX 16	Dr. Navani, BCR, B	Negative for pneumoconiosis
(same)	DX 31	Dr. Scott, BCR, B	Negative for pneumoconiosis
(same)	DX 31	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
May 15, 2001	EX 10	Dr. Scott, BCR, B	Negative for pneumoconiosis
(same)	EX 11	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	EX 7	Dr. Deponte, BCR, B	Negative for pneumoconiosis, COPD
June 8, 2001	DX 22	Dr. Dahhan, BCR, B	Negative for pneumoconiosis
(same)	DX 24	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	DX 24	Dr. Scott, BCR, B	Negative for pneumoconiosis

Discussion

Of the course of his life, from February 1980 to June 2001, Mr. Bolling’s lungs were irradiated at least seventeen times. Sixteen of those studies did not cause any dispute among the experts who interpreted the films. Fifteen of the chest x-rays (February 1, 1980, November 3, 1982, February 16, 1983, May 23, 1984, September 5, 1986, April 16, 1987, April 28, 1987, September 21, 1987, January 10, 1995, March 3, 1997, April 22, 1997, July 12, 1999, August 24, 2000, May 15, 2001, and June 8, 2001) were negative for pneumoconiosis. One chest film from September 4, 1987 was positive for pneumoconiosis.

The sole remaining x-ray, dated February 7, 2001, did cause a dispute among the physicians. Dr. Patel, a dual qualified radiologist, found sufficient evidence of pneumoconiosis. However, his

opinion is outweighed by the consensus of four similarly qualified radiologists, Drs. Barrett, Navani, Scott, and Wheeler, coupled with Dr. Rasmussen's interpretation, that the x-ray is negative. Accordingly, based on this preponderance of the expert opinion, I find this chest x-ray is also negative for pneumoconiosis.

In summary, of the seventeen chest x-rays in the record, sixteen are negative and clearly outweigh the sole positive interpretation. Mr. Bolling is unable to prove the presence of pneumoconiosis through radiographic evidence.

Medical Opinion

Although Mr. Bolling is unable to establish the presence of black lung disease in his lungs by chest x-rays, he may nevertheless still prevail on this element of entitlement according to 20 C.F.R. § 718.202 (4) if the preponderance of probative medical opinion, based on objective medical evidence, determines that he has pneumoconiosis as defined in 20 C.F.R. § 718.201.

Prior to examining the multiple medical evaluations in this case, a review of the other pulmonary function tests and all the blood gas studies helps place some of the medical assessments into perspective.

Pulmonary Function Tests

Exhibit	Date/ Doctor	Age/ height	FEV₁ pre post	FVC pre post	MVV pre post	%FEV₁/ FVC pre post	Qualified pre post	Comments
DX 35	Feb. 16, 1983 Dr. Berry	65/70"	1.58		16			Severe obstructive defect - invalid test per Dr. Gaziano, less than optimal effort
DX 35	Apr. 28, 1987 Dr. Byers	69 71"	0.38	0.76		50%		Invalid test, poor cooperation and effort
DX 35	Sep. 21, 1987 Dr. Capalad	69 71"	0.89	1.21	23	73%		Invalid test, poor cooperation and effort
DX 10	(same) Dr. Michos	--- ---	--- ---	--- ---	--- ---	--- ---	--- ---	Vents acceptable with suboptimal MVV performance

DX 36	Jan. 10, 1995 Dr. Forehand	76 68"	1.45 2.63	1.86 3.21	41 36	77% 81%	Yes ²¹ Yes	Moderately severe obstruction, partial reversible; tests valid per Dr. Michos
DX 36	May 18, 1995 Dr. Forehand	77 68"	1.77 2.84	2.17 3.68	70 89	81% 77%	No No	Partially reversible obstructive pattern
DX 37	April 22, 1997 Dr. Wicker	79 68.5"	1.22 1.25	2.64 2.81	30.1 30.1	46.2% 44.5%		Invalid test per Dr. Burki, less than optimal effort
DX 37	June 6, 1997 Dr. Wicker	79 68.5"	0.77 1.05	2.17 2.31	28.9 42.1	35.5% 45.5%		Invalid test per Dr. Burki, less than optimal effort

Arterial Blood Gas Studies

Exhibit	Date/ Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified ²²	Comments
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²¹The qualifying FEV₁ number is 1.73 for age > 71 and 68"; the corresponding qualifying FVC and MVV values are 2.24 and 69.

²²To qualify for Federal Black Lung disability benefits at a coal miner's given pCO₂ level, the value of the coal miner's pO₂ must be equal to or less than corresponding pO₂ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

DX 35	Feb. 16, 1983 Dr. Berry	40.1	87.2	No ²³	
DX 35	Oct. 27, 1986 Dr. Capalad	32.9	92	No ²⁴	
DX 35	April 28, 1987 Dr. Byers	38.3	74.1	No ²⁵	
DX 35	Sep. 21, 1987 Dr. Capalad	39.4	81	No ²⁶	
DX 36	Jan. 10, 1995 Dr. Forehand	35 37	74 78	No ²⁷ No ²⁸	
DX 37	April 22, 1997 Dr. Wicker	18.9	147	No ²⁹	
DX 11	February 7, 2001 Dr. Rasmussen	35	70	No	Unable to do exercise; previous CVA(cerebro- vascular accident)
DX 22	June 8, 2001 Dr. Dahhan	39.8	85.1	No	Unable to exercise due to heart and lung problems.

Dr. Bradley D. Berry
(DX 35)

On February 16, 1983, Dr. Berry conducted a pulmonary examination of Mr. Bolling, who complained about shortness of breath upon exertion. Mr. Bolling was also a non-smoker. Upon physical examination, Dr. Berry noted wheezing sounds. He diagnosed severe chronic obstructive pulmonary disease, bronchitis, and asthma. He related all three pulmonary conditions to Mr. Bolling's exposure to coal dust during 35 years of coal mine employment.

²³For the pCO₂ of 40 to 49, the qualifying pO₂ is 60, or less.

²⁴For the pCO₂ of 33, the qualifying pO₂ is 67, or less.

²⁵For the pCO₂ of 38, the qualifying pO₂ is 62, or less.

²⁶For the pCO₂ of 39, the qualifying pO₂ is 61, or less.

²⁷For the pCO₂ of 35, the qualifying pO₂ is 65 or less.

²⁸For the pCO₂ of 37, the qualifying pO₂ is 63, or less.

²⁹For the pCO₂ of 25 or below, the qualifying pO₂ is 75, or less.

Dr. Elpidio Capalad
(DX 35)

Dr. Capalad started treating Mr. Bolling in 1984 when he underwent cataract surgery. At the time of the May 23, 1984 treatment, Mr. Bolling complained about shortness of breath and the physician heard expiratory wheezes. Dr. Capalad diagnosed chronic obstructive pulmonary disease and pneumoconiosis by history.

Following a September 21, 1987 examination, Dr. Capalad again reiterated that Mr. Bolling was still wheezing and complained of worsening shortness of breath. At that time, Mr. Bolling was using an inhaler. Dr. Capalad continued with his diagnosis of COPD and "suspected pneumoconiosis, by history." According to Dr. Capalad, Mr. Bolling no longer could return to coal mining due to his breathing problems. The doctor added, "With his history of working in the mines for 34 years, I would suspect he is suffering from lung problems, possibly pneumoconiosis."

Dr. John G. Byers
(DX 35)

On April 28, 1987, Dr. Byers examined Mr. Bolling who presented with complaints about shortness of breath. In addition to his lengthy coal mine employment, and status as a non-smoker, Mr. Bolling reported the development of asthma about 15 to 20 years prior to the examination. At the time of the examination, Mr. Bolling was extensively using inhalers. During the examination, Dr. Byers heard distant crackles. A chest x-ray indicated scarring in the lower lobes of the lung. The pulmonary function test was invalid and the blood gas study showed mild resting hypoxemia.

Based on his examination, Dr. Byers concluded Mr. Bolling had a mild respiratory impairment in the nature of chronic bronchiectasis due to the lower lobe scarring with associated asthmatic condition. The bronchiectasis was unrelated to his coal mine employment. Dr. Byers found no evidence of coal workers' pneumoconiosis.

Dr. J. Randolph Forehand
(DX 36)

On January 10, 1995, Dr. Forehand examined Mr. Bolling. Mr. Bolling described his long history of coal mine employment of up to 24 years, including the early period of his employment when dust control measures were not in place. Mr. Bolling was a non-smoker who complained about shortness of breath upon exertion.

While the chest x-rays did not disclose the presence of pneumoconiosis, and the blood gas test was normal, the January 1995 pulmonary function test showed a totally disabling obstructive breathing defect. Dr. Forehand diagnosed coal worker's pneumoconiosis based on Mr. Bolling's

employment history, the physical examination, and the pulmonary function studies showing an obstructive defect. In the absence of the risk associated with cigarette smoke, Dr. Forehand opined that coal dust exposure was the etiology of the lung impairment because Mr. Bolling spent fourteen years underground prior to mandated dust control measures. Additionally, the obstructive pattern established in the pulmonary test was consistent with nonsmokers who have worked as coal miners.

When a May 1995 pulmonary function test produced much better results, Dr. Forehand changed his opinion on the extent of Mr. Bolling's impairment, finding that he was not totally disabled. At the same time, Dr. Forehand remained convinced that Mr. Bolling's pulmonary condition was caused by his lengthy exposure to coal mine dust.

Dr. N.C. Ratliff
(DX 21)

Between March 1995 and May 2000, Dr. Ratliff treated Mr. Bolling for several ailments. His numerous treatment notes document Mr. Bolling's struggles with bronchitis and his associated treatment with steroids and inhalers.

Dr. Mitchell Wicker
(DX 37)

On April 22, 1997, Dr. Wicker examined Mr. Bolling, who was a non-smoker. Mr. Bolling had a long period of coal mine employment. He complained about periodic wheezing attacks and shortness of breath. Upon physical examination, the physician heard occasional rhonchi. The chest x-ray was clear and the pulmonary function study invalid. Dr. Wicker stated he observed no evidence of pneumoconiosis. Due to Mr. Bolling's failure to comply with testing protocol, Dr. Wicker was unable to ascertain his respiratory capacity.

Dr. D.L. Rasmussen
(DX 11, DX 12 and DX 18)

On February 7, 2001, Dr. D.L. Rasmussen, board certified in internal medicine, conducted a pulmonary examination of Mr. Bolling. Mr. Bolling reported having been employed in the coal mines between 1932 and 1982, for a total of 30+ years, experiencing shortness of breath with exertion beginning some 25 years ago as a coal miner. Over the years, Mr. Bolling drilled and shot coal. He was a cutting machine operator and hand loader, with his last job being a loading machine operator. In addition, Mr. Bolling did considerable heavy manual labor. He set timbers, carried fifty pound rock dust bags 100 feet, sometimes used dynamite to blow up the bags, and shoveled to clean up.

As medical history, Mr. Bolling recalled having had pneumonia in 1991, attacks of wheezing

and heart disease, and strokes in 1998, 1999 and 2000. Mr. Bolling never smoked. He complained of sputum, wheezing, dyspnea, cough, chest pain, and edema. Pertinent physical findings revealed breath sounds moderately to markedly reduced with transient expiratory rales, plus increased expiratory phase with forced respirations. In addition, Mr. Bolling had evidence of a previous cerebrovascular accident with left hemiparesis, and he walked with a cane and with a limp. Mr. Bolling was on oxygen therapy and used various inhalers.

A chest x-ray indicated pneumoconiosis.. The ventilatory function studies revealed severe, partially reversible obstructive insufficiency. Maximum breathing capacity was markedly reduced. Resting blood gases were normal. Exercise studies were not performed because of Mr. Bolling's inability to walk on the treadmill secondary to his left side paralysis. Dr. Rasmussen believed these studies indicated a marked loss of lung function, such that Mr. Bolling did not retain the pulmonary capacity to perform his last regular coal mine job.

Dr. Rasmussen concluded Mr. Bolling had coal workers' pneumoconiosis and chronic obstructive lung disease ("COPD")/emphysema, both caused by coal mine dust exposure. He diagnosed coal workers' pneumoconiosis based on Mr. Bolling's 17+ years of coal mine employment and x-ray changes consistent with pneumoconiosis. His diagnosis of COPD/emphysema related to Mr. Bolling's coal mine employment was based on Mr. Bolling's chronic productive cough, airflow obstruction, significant history of exposure to coal mine dust, and status as a non-smoker.

In his Supplemental Report, dated April 19, 2001, Dr. Rasmussen acknowledged that other radiologists, and even he, had interpreted the chest x-ray as negative. Dr. Rasmussen was also aware that Social Security Administrative ("SSA") earning records only established eleven years of coal mine employment. Yet, his diagnosis of pneumoconiosis in the form of a chronic obstructive pulmonary disease related to coal dust exposure remained valid. Based on Mr. Bolling's explanation for the missing SSA records, Dr. Rasmussen concluded Mr. Bolling had an extensive history of coal mine employment. The physician further explained, since Mr. Bolling never smoked regularly, "the only known cause of his chronic lung disease would be his occupational dust exposure." While cigarette smoke is the most prominent cause of COPD, coal mine dust exposure can cause the same disease. Thus, Dr. Rasmussen remained convinced Mr. Bolling suffered a totally disabling chronic lung disease which was the consequence of his coal mine dust exposure.

Dr. Abdul Dahhan
(DX 22)

On June 8, 2001, Dr. Abdul Dahhan, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation of Mr. Bolling and a medical record review. Mr. Bolling's work history spanned 25 years of coal mine employment, ending 20 years earlier when the mine shut down. All of his employment work was underground where he operated a continuous miner and cutting machine and attended the belt head

Mr. Bolling was a non-smoker with a history of daily cough and productive clear sputum.

He had occasional wheezing and was on Proventil inhaler as needed averaging four to five times per day. He used oxygen 1.5 liters/minute primarily at night. He had been using the oxygen on and off for the last 15 years. He was also on Dyphyllin[®] liquid as needed for congestion and Amoxicillin every six hours for respiratory infection. He claimed dyspnea on exertion and walked with the assistance of a cane. He had two pillows orthopnea and occasional chest pain, with Nitroglycerin as needed.

Pertinent physical findings of the chest revealed good air entry to both lungs with no crepitation, rhonchi or wheezes. Cardiac examination showed regular rhythm with normal heart sounds. Arterial blood gases at rest showed normal values. Mr. Bolling did not undergo an exercise study because he was walking with the assistance of a cane and complained of heart and lung problems. Pulmonary function studies were invalid studies due to inconsistent effort. Mr. Bolling was not able to take in a deep breath and hold for 10 seconds. Chest x-ray showed clear lungs with no pleural or parenchymal abnormalities consistent with pneumoconiosis being present.

Based on his examination and review of Mr. Bolling's medical records,³⁰ Dr. Dahhan concluded there was insufficient objective data to justify the diagnosis of coal workers' pneumoconiosis. The physician observed the clinical examination, the blood gas studies, and Dr. Rasmussen's pulmonary function test results concerning FVC and lung volume measurements, were all normal. The chest x-ray was negative for the presence of pneumoconiosis. Mr. Bolling appeared to have a possible obstructive ventilatory defect, however, due to poor performance on his spirometry testing, the degree of the obstruction could not be assessed. Dr. Rasmussen's pulmonary study did show that Mr. Bolling responded significantly to bronchodilators, raising the possibility of hyperactive airway disease as a component of the patient's respiratory impairment.

Dr. Dahhan also found no evidence of pulmonary impairment and/or disability in Mr. Bolling's case caused by, contributed to, or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis. Mr. Bolling could very well have hyperactive airway disease as suggested by Dr. Rasmussen's spirometry which demonstrated significant response to bronchodilators therapy with the FVC rising from 72% to 91% of predicted. However, this finding is inconsistent with the permanent adverse affects of coal dust on the respiratory system.

Finally, Mr. Bolling did have multiple medical conditions that rendered him unable to return to his previous coal mining work, including his coronary artery disease, arthritis, old CVA (cerebrovascular accident), as well as his age. All are conditions of the general public at large and are not caused by, contributed to, or aggravated by, the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. James R. Castle

³⁰Dr. Dahhan reviewed the following records regarding Mr. Bolling: a chest x-ray dated 2/7/01 read by Dr. Patel, by Dr. Barrett, and Dr. Navani; arterial blood gases dated 2/7/01 from showing all normal values; and invalid spirometry from Dr. Rasmussen's office dated 2/7/01.

(EX 6)

On March 12, 2002, Dr. James R. Castle, board certified in pulmonary disease and internal medicine, reviewed all of the submitted medical data in Mr. Bolling's black lung claim, going back to the year 1983. Based upon a thorough review of all this information including medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gases, and other data, Dr. Castle concluded Mr. Bolling did not suffer from coal workers' pneumoconiosis.

According to Dr. Castle, although Mr. Bolling was credited for only about twelve years of mining employment, testimony and other data indicated that his exposure history was certainly sufficient enough to have caused him to develop coal workers' pneumoconiosis if he were a susceptible host. Mr. Bolling worked in various jobs in the mining industry including coal loader, cutting machine operator, utility man, and as a belt head watcher. He was a lifelong non-smoker.

A risk factor for the development of pulmonary disease and/or symptoms is that of bronchial asthma. Dr. Byers documented a history of asthma prior to 1987 for at least 20 years. Mr. Bolling not only had frequent episodes of wheezing, this condition worsen with hot and cold weather, and exposure to various fumes and vapors. He also demonstrated a very significant degree of reversibility on valid pulmonary function testing. All these findings are consistent with an asthmatic process which is not related to coal mining employment or coal dust exposure. Significantly, Mr. Bolling never received any therapy for this asthmatic process. He was not continuously or routinely treated with an anti-inflammatory drug such as inhaled steroids.

In addition, Mr. Bolling did not have any consistent physical findings indicating the presence of an interstitial pulmonary process. On some occasions, he did have evidence of rales or crackles that cleared with coughing. This indicated they were related to mucus production rather than an interstitial pulmonary process. He also demonstrated wheezing on some occasions while at other times he did not have wheezing. This variable finding of wheezing is consistent with an asthmatic process.

Since 1997, the vast majority of radiologists and B-readers found that there was no evidence whatsoever of pneumoconiosis radiographically. That was Dr. Castle's personal opinion as well. Only Dr. Patel found any evidence of pneumoconiosis. Dr. Patel felt that there was evidence of pneumoconiosis with a profusion of 1/0; yet, he initially considered the film might be negative. Nevertheless, it is Dr. Castle's opinion that there was no radiographic evidence of coal workers' pneumoconiosis.

A number of physiologic studies were done and were totally invalid. The studies did not represent Mr. Bolling's maximum physiologic effort and therefore should not be utilized to determine impairment and/or disability. On the other hand, several other studies were probably valid. All these valid studies showed evidence of very significantly reversible airway obstruction without restriction. Clearly, there was a marked degree of variability over both time and with bronchodilators therapy. These changes are indicative of bronchial asthma, not coal workers' pneumoconiosis. Dr. Rasmussen

obtained studies on 2/7/01 which showed moderately severe airway obstruction with a significant improvement after bronchodilators, particularly in the forced vital capacity. Finally, all the blood gas studies were normal.

Dr. Castle concluded that Mr. Bolling had a significant degree of airway obstruction which was highly variable over time. It was also significantly reversible after bronchodilators therapy. The breathing problem was associated with hyperinflation and gas trapping, which are indicative of bronchial asthma. When coal workers' pneumoconiosis causes impairment, it generally does so by causing a mixed, *irreversible* obstructive and restrictive ventilatory defect. That was not the finding in this case. In Dr. Castle's opinion, Mr. Bolling had impairment resulting in disability due to bronchial asthma. He did not have any pulmonary impairment due to coal workers' pneumoconiosis or coal mine dust exposure. In other words, Mr. Bolling did not suffer from coal workers' pneumoconiosis because he did not have the physical findings, the radiographic findings, the physiologic findings, or the arterial blood gas findings to indicate the presence of that process.

However, Mr. Bolling did have a respiratory impairment which may be disabling. This impairment is due to bronchial asthma. Mr. Bolling has no respiratory impairment which has arisen from his coal mining employment or coal workers' pneumoconiosis. With proper treatment, Mr. Bolling might achieve a level of respiratory function that would be above federal disability standards. But, Dr. Castle believed he would still be disabled due to bronchial asthma, his age, multiple cerebrovascular accidents, and other medical problems. Those conditions afflicted the general public at-large and are unrelated to coal mining employment and coal dust exposure.

Even if radiographic evidence of simple coal workers' pneumoconiosis existed, Dr. Castle would not change his opinion concerning absence of a pulmonary impairment due to that process. Essentially, Mr. Bolling did not have the physiologic changes indicating impairment and/or disability due to coal workers' pneumoconiosis.

Dr. Gregory J. Fino
(EX 5)

On March 13, 2002, Dr. Gregory J. Fino, board certified in pulmonary disease and internal medicine, reviewed Mr. Bolling's employment history and the medical record concerning his pulmonary condition since 1980. Mr. Bolling had worked as a belt watcher, which included lifting 100 pounds at a frequency of three times per day. He also carried 15 pounds all day, stood for 10 hours per day and crawled a distance of one mile. Previous forms indicated that he had also worked in the mines on a cutting machine and on the tippie. Additionally, he had hauled and loaded coal.

In Dr. Fino's opinion, Mr. Bolling experienced a sufficient amount of coal mine dust exposure to have caused coal workers' pneumoconiosis. Further, Mr. Bolling never smoked, so smoking is not a risk factor for lung disease in this case. However, the objective testing regarding Mr. Bolling's

effort during lung function tests was uniformly noted to have been sub-optimal and poor. He never gave a maximum effort on any of the lung function studies, post 1997. Consequently, none of the tests were valid to establish a pulmonary impairment. In addition, Mr. Bolling's multiple room air arterial blood gases tests were normal.

In effect, Dr. Fino found no objective evidence of a coal mine dust related pulmonary condition. Even if he were to assume that Mr. Bolling had legal pneumoconiosis, there was no valid, objective evidence of any respiratory impairment. Thus, Mr. Bolling did not have pneumoconiosis, respiratory impairment, or pulmonary disability. He was neither partially nor totally disabled from returning to his last mining job requiring similar effort.

Discussion

Obviously, the medical opinion concerning the presence of coal workers' pneumoconiosis in Mr. Bolling's lungs is diverse. In light of this medical disagreement, I must first assess the relative probative value of each medical evaluation and then determine whether Mr. Bolling is able carry his burden of proving the presence of pneumoconiosis through the preponderance of the more probative medical opinion. The two factors I consider in evaluating relative probative weight are: a) documentation and b) reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation, such as chest x-rays, pulmonary function tests, arterial blood gas studies, and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. See *Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998). The second factor of reasoning involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I first find the medical treatment notes from Dr. Ratliff have little probative weight on this issue. Although he was apparently Mr. Bolling's treating physician and documented his chronic bronchitis, Dr. Ratliff did not render an opinion on whether his patient had black lung disease.

Similarly, after conducting a well documented medical record review, Dr. Fino offers little probative help on this issue. In his analysis, Dr. Fino primarily focused on the absence of any valid

objective testing to establish the presence of a pulmonary impairment. In his discussion on why Mr. Bolling did not have a verifiable respiratory disability, Dr. Fino did state Mr. Bolling had no impairment due to his coal dust exposure. But that statement has little probative value because Dr. Fino did not include any discussion on the evidence as it relates to the presence or absence of coal workers' pneumoconiosis. Additionally, given Dr. Fino's emphasis on the absence of an impairment, his conclusion is ambiguous since it may simply mean Mr. Bolling has no pulmonary impairment due to any cause.

In 1983, based on pulmonary testing showing an obstructive impairment, Dr. Berry concluded Mr. Bolling had COPD, bronchitis, and asthma, all related to his coal mine dust employment. Dr. Berry's conclusion has diminished probative value for both documentation and reasoning shortfalls. Due to the dated nature of his examination, his opinion obviously is not as well documented as more recent evaluations. Additionally, Dr. Berry based his diagnosis on a pulmonary function test that was subsequently determined to be invalid and additionally impeached by later tests showing much less obstruction. Finally, Dr. Berry set out his conclusion in a terse nature on the examination report without providing any reasoning for his diagnoses.

In 1984, Dr. Capalad also diagnosed pneumoconiosis. However, his opinion has little probative value because it was poorly documented and equivocal. Notably, Dr. Capalad based his diagnosis on "history" and on Mr. Bolling's length of coal mine employment without identifying any objective medical support. The absence of specific documentation became more apparent in 1987 when Dr. Capalad also equivocally expressed his conclusion using the terms "suspected" and "possibly" to qualify the word, "pneumoconiosis."

Dr. Byers' 1987 opinion that Mr. Bolling struggled with asthma but not pneumoconiosis is also dated. Absent more complete documentation, his assessment has little probative value.

The 1995 finding of coal workers' pneumoconiosis by Dr. Forehand is more modern but still not as well documented as the opinions of physicians who reviewed the entire record. His reasoning is also somewhat tarnished because he relied principally on the January 1995 pulmonary function test showing a substantial, and disabling, pulmonary impairment. When a repeat May 1995 series of pulmonary tests produced much better results, Dr. Forehand merely changed his assessment about the extent of Mr. Bolling's disability without extensively discussing how the later test, which clearly established variability in the nature of Mr. Bolling's pulmonary obstruction defect, still supported his diagnosis of pneumoconiosis, which is considered a disease that causes permanent damage and is not susceptible to improvement.

Dr. Wicker's 1997 assessment that Mr. Bolling did not have black lung disease was based on documentation limited to his examination and further reduced by the absence of a valid pulmonary study. This limited documentation diminishes the probative value of his opinion.

Following his 2001 examination of Mr. Bolling, Dr. Rasmussen concluded Mr. Bolling had pneumoconiosis based both on a positive chest x-ray and COPD caused by exposure to coal dust.

When other interpretations, including his own, of that x-ray were negative, Dr. Rasmussen dropped the his diagnosis of pneumoconiosis by chest x-ray. However, according to Dr. Rasmussen, since Mr. Bolling was a non-smoker, the only other pulmonary risk factor for his development of COPD was his extensive coal dust exposure.

While Dr. Rasmussen did prove significant reasoning for his opinion, his assessment has lesser, relative probative weight than Dr. Dahhan's and Dr. Castle's evaluations in terms of documentation and reasoning. Unlike Dr. Dahhan and Dr. Castle, Dr. Rasmussen did not conduct a review of Mr. Bolling's medical record. Instead, he relied on the medical history provided by Mr. Bolling. In that history, Mr. Bolling reported that he had never experienced bronchial asthma.³¹ The only past pulmonary problem he reported was a bout with pneumonia. In light of the notations from Dr. Berry and Dr. Byers documenting asthma, and Mr. Bolling's prescription medication for inhalers, Dr. Rasmussen clearly relied on an incorrect medical history. That reliance adversely affects the probative value of his opinion because he did not even consider asthma as a possible explanation for Mr. Bolling's demonstrated obstructive defect. Instead of three potential causes for the obstruction, asthma, coal dust, and cigarette smoke, Dr. Rasmussen only focused on the later two potential risks. Finding Mr. Bolling a non-smoker, he concluded coal dust was the cause.

Even in the absence of consideration of asthma, Dr. Rasmussen's opinion also contains less than complete reasoning because he failed to address the variability in the pulmonary function tests. As highlighted by Dr. Dahhan and Dr. Castle, the degree of Mr. Bolling's pulmonary obstruction varied from pulmonary test to pulmonary test. Likewise, the condition consistently responded and improved with the application of bronchodilators. Dr. Rasmussen failed to reconcile that variability with the permanent, and non-improving, lung damage caused by coal workers' pneumoconiosis.

Additionally, in terms of probative value, to some degree, Dr. Rasmussen's professional standing is somewhat diminished in relation to Dr. Dahhan and Dr. Castle. All three doctors are board certified physicians. However, only Dr. Dahhan and Dr. Castle are board certified in pulmonary medicine.

As the sole physician in this record to both examine Mr. Bolling and conduct a review of his medical record, Dr. Dahhan, a board certified pulmonologist, presented the best documented opinion in the record. Based on that extensive documentation, he presented a reasoned conclusion that Mr. Bolling did not have pneumoconiosis. Although Mr. Bolling did struggle with a pulmonary obstruction, that possible impairment, which was not measurable due to the multiple invalid tests, exhibited both a variability characteristic over time and a responsiveness to bronchodilators that was inconsistent with pneumoconiosis. Dr. Dahhan believed that absence of permanent adverse effects, and some portions of Dr. Rasmussen's pulmonary testing, suggested Mr. Bolling was troubled by hyperactive airways, a condition unrelated to his coal mine employment.

Finally, turning to Dr. Castle, a board certified pulmonologist, I consider his opinion that Mr.

³¹In 1987, Mr. Bolling reported to Dr. Byers that he had been struggling with asthma for 15 to 20 years.

Bolling does not have coal workers' pneumoconiosis to be very well documented and the best reasoned assessment of Mr. Bolling's pulmonary impairment. Dr. Castle did not actually examine Mr. Bolling. However, he overcame any handicap attributable to the absence of a hands-on experience with Mr. Bolling by extensively reviewing and summarizing the results of each pulmonary examination and the associated physician's conclusions. In terms of comprehensiveness, his review identified three, rather than two, potential sources of Mr. Bolling's obstructive defect: cigarette smoke, coal dust, and asthma.

After eliminating cigarette smoke as a cause because Mr. Bolling was a non-smoker, Dr. Castle provided a detail explanation for his discriminating between a coal dust related obstruction and asthma. Observing the preponderance of radiographic evidence was negative for pneumoconiosis and going farther than Dr. Dahhan's suggestion of hyperactive airways, Dr. Castle noted Mr. Bolling's past history of asthma. That medical history coupled with valid pulmonary function tests showing very significantly reversible airway obstruction without restriction, led Dr. Castle to identify asthma, and not coal workers' pneumoconiosis, as the etiology of Mr. Bolling's respiratory impairment. The changes in the pulmonary function studies were more consistent with bronchial asthma than coal workers' pneumoconiosis. According to Dr. Castle, when coal workers' pneumoconiosis causes impairment, it generally causes a mixed, irreversible obstructive and restrictive ventilatory defect and does not improve. In contrast, Mr. Bolling's impairment varied over time and improved with the administration of inhalers.

In summary, for various documentation and reasoning factors, I find the conclusions of Dr. Dahhan, and Dr. Castle that Mr. Bolling does not have coal workers' pneumoconiosis are the best documented and reasoned medical opinions in the record; are most consistent with all the medical evidence in the record; and, outweigh Dr. Rasmussen's finding of coal workers' pneumoconiosis. Consequently, the preponderance of the more probative medical opinion indicates that Mr. Bolling does not have coal workers' pneumoconiosis.³²

CONCLUSION

Because he now suffers a totally disabling pulmonary impairment, Mr. Bolling has established a material change in condition. However, after considering all the evidence in the entire record, I find neither the preponderance of the chest x-ray evidence nor the more probative medical opinions establishes that Mr. Bolling has coal workers' pneumoconiosis. Due to that absence of sufficient evidence to prove the presence of pneumoconiosis, Mr. Bolling has failed to prove the first requisite element for the entitlement of benefits under the Act. Accordingly, Mr. Bolling's claim for benefits must be denied.

³²Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203, (4th Cir. 2000), I must consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Bolling has pneumoconiosis. In that regard, since standing alone neither the preponderance of chest x-rays nor the more probative medical opinion establishes the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

ORDER

The claim of MR. RAY BOLLING for benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: May 29, 2003
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.